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Employer **focus**

Benefits Compliance Newsletter for Employers | Q2 2025

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2nd Quarter Benefit News Highlights

1 __ Supreme Court Decision – ADA Protections Not Applicable to Retiree Benefits

In Stanley v. City of Sanford, Florida, the U.S. Supreme Court ruled that retirees are not protected under Title I of the Americans with Disabilities Act (ADA) if they are no longer employed or seeking employment. The case involved a former firefighter who retired due to disability and received fewer health benefits than service-based retirees. The Court held that Title I of the ADA only applies to "qualified individuals" who currently hold or seek a job and can perform its essential functions. As such, the ADA does not cover post-employment benefit disparities for individuals who are no longer part of the workforce. The Supreme Court's decision can be found here – https://www.supremecourt.gov/opinions/24pdf/23-997_6579.pdf

2 __ Insurers' Pledge to Simplify Prior Authorizations

Health insurers that are part of AHIP, a national trade association representing health insurance companies, have pledged to simplify the prior authorization process through several key reforms. They aim to implement standardized electronic prior authorization systems by January 1, 2027, reduce the number of services requiring prior authorization by January 1, 2026, and ensure continuity of care by honoring existing prior authorizations for 90 days when patients switch plans mid-treatment. Some of these things are not new and may already be required of insurers, but perhaps with this pledge and the agreement to post data publicly about prior authorization, we will see improvements for patient access to care and a reduction in administrative burdens for providers over time. The details of this pledge and a list of participating insurers can be found here – https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization

3 __ Final Rule – 2025 Marketplace Integrity and Affordability

The Centers for Medicare & Medicaid Services (CMS) finalized a rule that may have a significant impact on individual health coverage available through public Marketplaces beginning in 2026. Amongst other things, the rule shortens the open enrollment window to Nov. 1 – Dec. 15 for federally-run Marketplaces and requires that no Marketplace offer an open enrollment longer than Nov. 1 – Dec. 31; increases eligibility verification and reconciliation requirements for premium tax credits; and adjusts the methodology used to set premiums. It is estimated that some of these changes may result in lower overall premiums and will reduce improper enrollments and payment of premium tax credits. However, the changes might also make it more difficult to obtain individual coverage and qualify for premium tax credits through public Marketplaces.

In addition to the Marketplace changes, the rule prohibits individual and small group fully-insured plans from providing coverage for specified sex-trait modification procedures as an essential health benefit and provided the 2026 out-of-pocket (OOP) maximums for ACA group health plans. The 2026 maximum OOP is $10,600 for self-only coverage and $21,200 for other than self-only coverage (currently $9,200 and $18,400 for 2025).

A link to the final rule fact sheet can be found here – https://www.cms.gov/newsroom/fact-sheets/2025-marketplace-integrity-and-affordability-final-rule

4 __ Supreme Court Decision – Transgender Coverage

In U.S. v. Skrmetti, the Supreme Court upheld Tennessee's law banning puberty blockers and hormone therapy for transgender minors, ruling that the law does not violate the Equal Protection Clause because the restriction applies regardless of a minor's sex. This decision marks a significant departure from the Biden administration's position supporting the challenge to Tennessee's law and aligns more closely with the Trump administration's stance reversing that support earlier this year. This ruling is expected to bolster similar restrictions in other states and signals a narrowing interpretation of equal protection in the context of gender-affirming care. The Supreme Court decision can be found here - https://www.supremecourt.gov/opinions/24pdf/23-477_2cp3.pdf

5 __ Draft Forms 1095-B and 1095-C

This week the IRS released draft Forms 1095-B and 1095-C, which will be used to collect data for the 2025 calendar year early in 2026. The forms look similar to prior years' forms and thereby suggest there won't be any significant changes to ACA employer reporting for 2025. However, we won't know for sure until final forms and instructions are made available later this year. The draft forms can be found here:

- Draft Form 1095-B - https://www.irs.gov/pub/irs-dft/f1095b--dft.pdf
- Draft Form 1095-C - https://www.irs.gov/pub/irs-dft/f1095c--dft.pdf

6 __ Tobacco Surcharge Challenges

Legal challenges continue to arise regarding tobacco surcharge programs, where employers apply additional charges or higher premium contributions for employees who use tobacco or nicotine. While some cases have been settled, many remain unresolved. Notably, two recent challenges have survived motions to dismiss – Bokma v. Performance Food Grp., Inc., (E.D. Va. 2025) and Mehlberg v. Compass Grp. USA, Inc., (W.D. Mo. 2025). Historically, such challenges have focused on the failure to offer or notify employees of a reasonable alternative standard. However, these two recent cases allege that employees who met the alternative standard mid-year were not granted retroactive removal of the surcharge, thereby denying them the full reward required under HIPAA. While we continue to watch how the courts rule on these challenges, employers with tobacco surcharge programs in place should carefully review their practices to ensure compliance with HIPAA wellness program rules as well as EEOC/ADA if medical testing is used to verify tobacco or nicotine use.

7 __ Taxation of Fixed Indemnity Plans

The American Benefits Council (ABC) requested that the IRS clarify the tax treatment of fixed indemnity plan benefits when premium payments are made by the employer or made by employees pre-tax through a cafeteria plan. With the 2023 proposed rules still unfinalized, uncertainty remains over whether the full benefit amount or only the portion exceeding medical expenses should be considered taxable. ABC acknowledged that many current wellness arrangements include indemnity plans, which may be the focus of IRS scrutiny, but emphasized the need to address the taxation of fixed indemnity benefits independently. They urged the IRS to separate this issue from broader enforcement efforts targeting potentially non-compliant wellness schemes.

ABC's letter can be found here - https://www.americanbenefitscouncil.org/pub/?id=4fc55325-e2cf-1ac8-3889-5c2e1489d806

8 __ Fiduciary Duties & TPAs

In Tiara Yachts, Inc. v. Blue Cross Blue Shield of Michigan (BCBSM), the Sixth Circuit held that a TPA may be considered a fiduciary under ERISA when it exercises discretion over plan assets or compensation. BCBSM allegedly used a “flip logic” system where BCBSM overpaid claims and then profited from clawbacks through a Shared Savings Program. The decision reversed a lower court’s dismissal, allowing claims for breach of fiduciary duty and prohibited transactions to proceed. This ruling is another reminder of the importance of employer oversight of TPAs and could expand fiduciary liability exposure for service providers managing self-funded health plans depending on how this plays out.

9 __ One Big Beautiful Bill Act (OBBBA)

The massive budget reconciliation bill known as OBBBA passed the House last week. As with many such budget bills, there were various employee benefits related provisions tucked into its depths, some small, some quite significant. Before we summarize those provisions, just a quick civics lesson reminder.

The bill has only passed the House; it is not yet law. It still has to clear the Senate, where it is likely to be changed, and then pass reconciliation between the House and Senate before being presented to President Trump for signature. During that process, any of the provisions discussed below might be changed or stripped out of the bill or the bill as a whole might simply fail to win passage. So pay attention to how the bill progresses, but don’t go planning 2026 plan design changes just yet. The potential benefit-related changes are as follows:

- **HSAs**. The most significant changes would be to HSAs. The bill would allow individuals to enroll in Medicare Part A, certain direct primary care arrangements, and a spouse’s health FSA without causing a loss of HSA-eligibility. In addition, gym membership fees up to a specified dollar limit would be eligible HSA expenses, and HRA and health FSA funds could be rolled over to an HSA under certain circumstances. Finally, the maximum annual contribution limit would be increased significantly, but to a lesser extent for those who earn $75,000 or more per year. Notably absent from these changes is relief for telehealth. This would seem to be the perfect vehicle to allow telehealth not to interfere with HSA-eligibility, but there is no mention of it.
- **ICHRAs**. The bill codifies the individual coverage HRA (ICHRA) regulations and changes the name to CHOICE arrangements. There are no substantive changes to the ICHRA rules, but employees would be allowed to pay for premiums for Exchange/Marketplace coverage on a pre-tax basis (currently this is only allowed for non-Exchange policies). There would also be a tax credit available to small employers (<50 FTEs) who offer a CHOICE plan.
- **Miscellaneous**. Payment or reimbursement of student loan payments would be made a permanent education expense eligible for tax-free reimbursement under IRC §127 (currently set to expire at the end of 2025) and the maximum §127 reimbursement limit would be indexed for inflation. The bill also permanently eliminates the bicycle commuting expense from Qualified Transportation Plans under §132(f).

10 __ Transparency Updates

Federal agencies recently provided new guidance and requests for information to strengthen the implementation and enforcement of healthcare transparency rules as directed by Trump's Executive Order. This does not change anything specific to employer compliance obligations, but has the potential to provide further access to healthcare spend data. The guidance and requests for information (RFIs) can be found here and are summarized below - https://www.cms.gov/newsroom/press-releases/departments-labor-health-and-human-services-treasury-announce-move-strengthen-healthcare-price

- **Machine-Readable Files.** The Departments of Labor, HHS, and Treasury introduced Schema Version 2.0 for machine-readable files under the Transparency in Coverage Final Rule, aiming to reduce file size and improve clarity by eliminating duplicative data. In addition, an RFI was issued to gather input on prescription drug machine-readable files, which are currently delayed pending further guidance. The RFI focuses on implementation challenges and potential alternatives and suggests regulations to implement the prescription drug portion of the machine-readable files requirement are in the works.

- **Hospital Price Transparency.** CMS issued updated guidance for hospitals, requiring actual dollar amounts in pricing files instead of estimates. CMS also issued an RFI to gather input on how to increase compliance and ensure that accurate and complete data is shared.

11 CRS Report – Preventive Coverage

Last week, the Congressional Research Service (CRS) released a report detailing the current federal framework for preventive health services coverage. Under the Affordable Care Act (ACA), most group health plans must cover preventive services (e.g., immunizations, cancer screenings, and contraception) without cost-sharing based on recommendations from several federal agencies. The report also explores the potential impact of ongoing litigation, including *Braidwood v. Becerra*, which challenges the ACA's preventive mandate and could affect what group health plans are required to cover without cost-sharing. CRS emphasizes how these federal requirements intersect with public programs and payment systems, shaping the broader landscape of preventive care access. The report can be found here - https://www.congress.gov/crs-product/IF13010

12 Mental Health Parity – Non-Enforcement of Final Rule

Based on a May 9th court filing, the DOL and HHS have indicated they intend to publish a non-enforcement policy with respect to certain provisions of the Mental Health Parity & Addiction Equity Act (MHPAEA) final rule that were effective beginning in 2025 and 2026 pending a complete review of the final rule. We are waiting on the formal non-enforcement language to get further clarity on exactly what portions of the final rule can be ignored, but we anticipate the new fiduciary certification requirement, certain new definitions, the "meaningful benefits" requirement, and the requirement to collect and analyze relevant data may no longer be required. The written comparative analysis for non-quantitative treatment limitations (NQTLs) is still required as it was added by Congress in the Consolidated Appropriations Act of 2021 along with a high-level description of the content that should be included. We encourage employers to continue with such efforts in case of agency audit or participant request until there is something very clear indicating otherwise from Congress or the agencies. We will continue to carefully monitor this situation.

13 Executive Order Aimed at Lowering Drug Prices

In mid-April, President Trump released an executive order directing the agencies to take action to promote innovation and competition, accelerate the drug approval process, and increase drug importation, amongst other things, to hopefully result in the lowering of drug prices over time. Of interest to brokers and employer sponsors of group health plans, the Department of Labor (DOL) was directed to expand upon the broker disclosure requirements set forth in ERISA 408(b)(2)(B) within 180 days to provide more transparency around the direct and indirect compensation received by pharmacy benefit managers. There are no immediate changes or requirements, but we expect to see more from the DOL on this later this year. The full text of the executive order can be found here – https://www.whitehouse.gov/presidential-actions/2025/04/lowering-drug-prices-by-once-again-putting-americans-first/

14 Reminder – RxDC Reporting

Annual RxDC reporting is required by June 1 of each year. Reporting for the data from 2024 will be due June 1, 2025. The reporting consists of a plan file (P2) , eight data files (D1 – D8) and accompanying narratives. Most employer-sponsored health plans rely heavily on their carriers, TPAs, and PBMs to provide the data necessary, and in many cases, to submit the reporting to CMS on behalf of employer group health plans. To complete the reporting, carriers or TPAs may have reached out to employers asking for information about premium splits (employer and employee contributions) as well as other data required for the D1 file. Once this information is provided, the carrier, TPA and/or PBM may handle the entirety of a group health plan's RxDC reporting. However, for employers who failed to timely respond with the requested data, or if the carrier/TPA is unwilling to help with the D1 file, the employer may have to submit a P2 and D1 file on their own.

15 __ Employer Mandate – Successful Challenge of IRS Collection of §4980H Penalties

An employer that did not offer medical coverage to full-time employees received an IRS Letter 226J proposing an employer shared responsibility payment of approximately $200,000 for 2019. The employer paid the penalty under protest, later requested a refund that was not granted by the IRS, and then filed a claim challenging the IRS' ability to collect such penalty payment. The employer claimed that the IRS should not have been able to collect the penalty because the employer never received Marketplace certifications notifying the employer of employees who enrolled in subsidized Marketplace coverage. Such step is technically a required part of the §4980H enforcement process. A federal court in the Northern District of Texas found in favor of the employer indicating that the failure of the Department of Health & Human Services (HHS) to send Marketplace certifications to the employer did not provide the employer with the required notice and opportunity to appeal, so the IRS penalties were not enforceable. The employer received a refund.

What will this mean for §4980H offer of coverage requirements and IRS enforcement efforts going forward? It's unclear whether the IRS will be able to enforce §4980H penalties if employers don't first receive Marketplace certifications, but the decision could be appealed to a higher federal court and/or the IRS and HHS could make changes to the current process. This is certainly something to watch, but for now, applicable large employers (50 or more FTEs) should continue to offer minimum value, affordable coverage to full-time employees and their dependent children and report on such offers of coverage using Forms 1094-C and 1095-Cs. The court's decision can be found here: https://litigationtracker.law.georgetown.edu/wp-content/uploads/2024/07/Faulk_2025.04.10_MEMORANDUM-OPINION-AND-ORDER.pdf

Some applicable large employers who made an employer shared responsibility payment (ESRP) in response to an IRS Letter 226J have been successful in requesting refunds from the IRS based on the court's recent decision in Faulk v. Becerra. Contact us for more information or assistance in filing for a refund.

16 __ Updated CHIP Notice

The State Premium Assistance Notice for Medicaid and CHIP informs employees of potential opportunities for premium assistance available in the state in which they reside. Employers are required to distribute the CHIP notice annually to all eligible employees who live in a state offering premium assistance, so most employers distribute the notice to all employees who are eligible for the employer's group health plan during each open enrollment. The recently updated version of the CHIP notice can be found here – https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/2010-2409

17 __ San Francisco Health Care Security Ordinance

The San Francisco Health Care Security Ordinance (HCSO) requires most San Francisco employers to spend a minimum amount on health care for employees working in San Francisco and to report on such expenditures to the Office of Labor Standards Enforcement (OLSE) annually. The annual report form is now available and is due 5/2/2025. Submit an Employer Annual Reporting Form to OLSE | SF.gov

18 __ Final CMS Instructions – Changes to Simplified Method Determinations for 2026

Employers that provide prescription drug coverage are not required to offer creditable coverage, but are required to determine whether the coverage is creditable and to communicate creditable status annually to eligible individuals and to the Centers for Medicare & Medicaid Services (CMS). Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of Medicare Part D coverage.

Most plan sponsors have the option to determine creditable status by obtaining an actuarial determination or by using a "simplified method" as defined by CMS. CMS final instructions released earlier this week set forth revised criteria for the simplified method. A plan must meet all of the following to be creditable:

- Must provide reasonable coverage for brand name and generic prescription drugs and biological products;

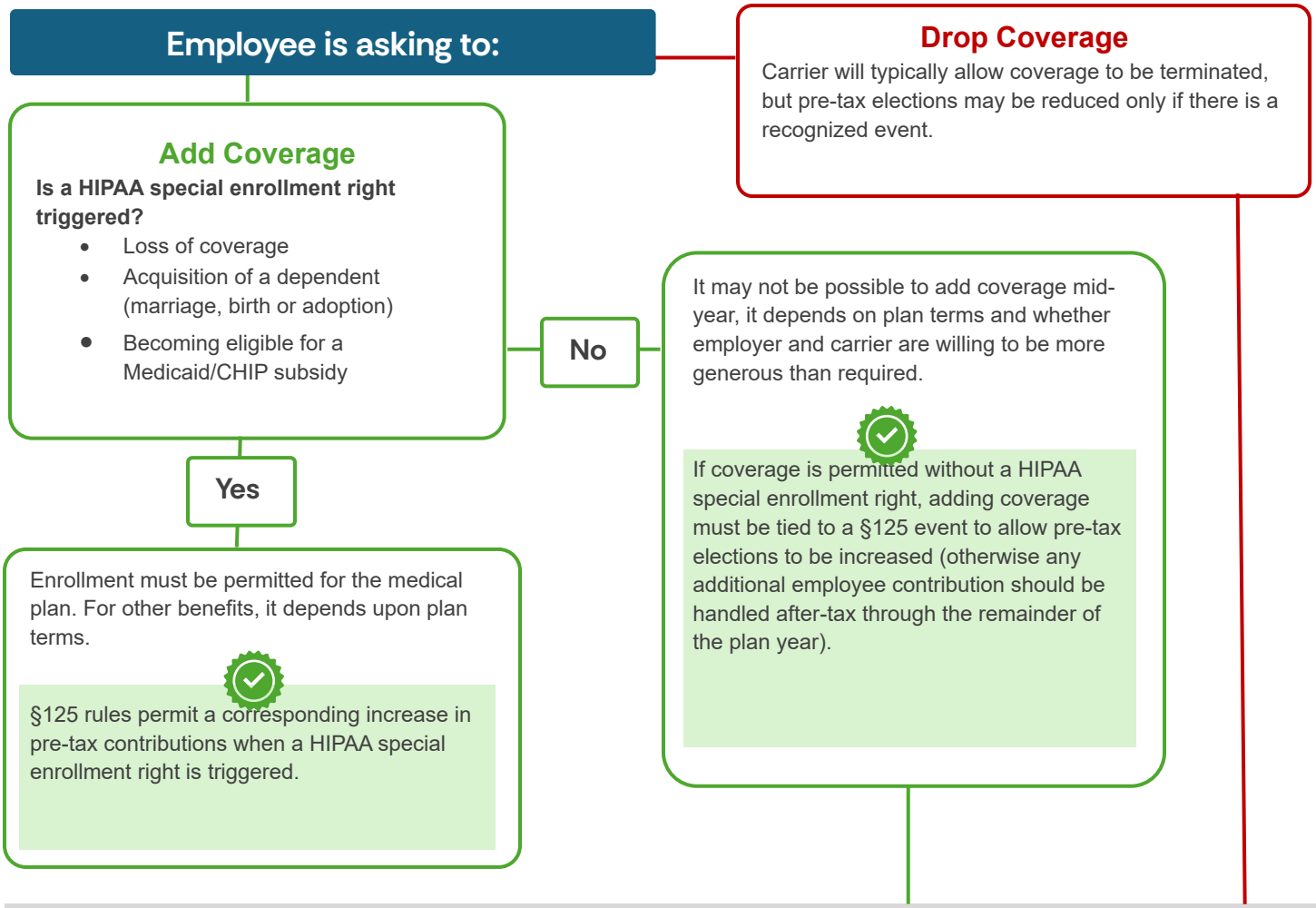
- Must provide reasonable access to retail pharmacies; and
- Must be designed to pay on average at least 72% of participants' prescription drug expenses.

For 2026 plan years, CMS will permit plans to use either the existing simplified determination methodology or the revised simplified determination methodology described above to determine whether prescription drug coverage under their CY 2026 plans is creditable. The final instructions can be found here - https://www.cms.gov/files/document/final-cy-2026-part-d-redesign-program-instruction.pdf

19 Level-Funded Plan Surpluses

For employers who offered a level-funded plan during 2024, the employer may receive a surplus payment from the carrier. The safest approach is to handle such payments similarly to an MLR rebate, returning a percentage of the payment to current plan participants in accordance with the percentage of the premiums that were contributed by plan participants. For example, if plan participants contributed 40% of the plan's annual premium payments (the employer contributed 60%), 40% of the payment should be distributed amongst current plan participants within 90 days of receipt, generally as a premium holiday or as taxable cash. However, if the level-funded plan document specifically states that any surplus funds belong exclusively to the employer, then the employer can follow the terms of the plan and would be able to keep the entire payment and use it toward any business expenses.

FEATURE: Mid-Year Election Changes Flow Chart



List of §125 Events:

- Change in status:
  - Change in employee's legal marital status
  - Change in number of dependents
  - Change in employment status
  - Change in dependent eligibility status
  - Change in residence
  - Commencement/termination of adoption proceedings
- Change in cost of benefits or significant curtailment or improvement of benefits
- Change in coverage under other employer plan (including having a different plan year)
- Loss of group health coverage sponsored by governmental or educational institution
- HIPAA special enrollment
- COBRA qualifying event
- Medicare or Medicaid entitlement
- FMLA
- Enrollment in other minimum essential coverage

FEATURE: Domestic Partner Benefits

While opposite-sex and same-sex marriages are permitted nationwide, today's workforce presents a wide variety of relationship arrangements for which a domestic partner benefit offering provides more flexibility. In addition, while most employers are not required to offer benefits to domestic partners, doing so may provide additional protection against claims of discrimination based on gender. For employers who offer coverage to domestic partners, and maybe to their children as well, it is important to ensure the administration and taxation are handled in a compliant manner.

Eligibility

Federal, State and Local Requirements

Under federal law, employers are not required to offer coverage to domestic partners. However, there are a handful of states (notably California) that do require plan eligibility rules to include registered domestic partners (i.e., those who are formally registered as domestic partners in accordance with state or local laws). These state requirements would generally only apply to fully-insured ERISA plans issued in that state and self-funded non-ERISA plans. Self-funded ERISA plans can disregard state insurance mandates because of ERISA preemption.

In addition, several state and local governments require their contractors to provide domestic partner coverage as a condition of doing business with that government unit. Since these requirements are a condition of the employer being a government contractor, ERISA does not preempt them.

Eligibility Rules

Except in those states that mandate domestic partner coverage, there is no uniform definition of who qualifies as a "domestic partner." That means the plan itself must define what it means for someone to be a domestic partner eligible for coverage under the plan. Some carriers and TPAs have standard definitions they use in their boilerplate plan documents. In other cases, the employer must come up with a definition on its own and/or decide whether to modify the standard definition provided by the carrier or TPA.

Examples of common factors used to define domestic partner status:

- Age requirement (e.g., 18+)
- Currently living together and have lived together for some specified period of time
- Shared financial responsibility such as joint bank accounts, joint lease or mortgage, or shared utility bills
- Not married to or in a domestic partnership with anyone else
- Partners are no more closely related than would be allowed for spouses under state law
- Formal registration on a domestic partnership or civil union registry *(keep in mind formal registries are only available in a limited number of states and local jurisdictions, so requiring registration may severely limit the availability of the benefit depending on where employees live)*

The eligibility rules could also include the children of the domestic partner. Children of a domestic partner in this context refer specifically to children who are not the employee's own biological or adopted children but rather a status akin to stepchild. Biological or adopted children the employee has with their domestic partner will generally be eligible for coverage regardless of the availability of domestic partner coverage.

Verification of Eligibility

Employers are not required to obtain an attestation or any additional documentation to prove a domestic partner's status, especially if the employer does not require any documentation from spouses permitted to enroll. However, it is possible to require an attestation of meeting certain requirements or to require evidence of the relationship. A simple attestation that the

domestic partner meets the plan eligibility requirements may be sufficient and is often easiest to collect administratively. Employers could take it one step further and require such attestation to be notarized. In addition, employers could require documentation proving things such as a common address or shared finances. Any domestic partner affidavit or attestation should be tailored to match the plan's specific definition of domestic partner eligibility.

Taxation of Domestic Partner Benefits

Many benefits can be offered on a tax-favored basis to employees and to the employee's spouse and tax dependents, but if benefits are offered to those who do not qualify as the employee's spouse or tax dependent, then the coverage is taxable. If a domestic partner, or a child of the domestic partner, does not qualify as a Code §105(b) dependent of the employee, the employer must treat the fair market value (FMV) of the coverage provided to the domestic partner or child as taxable income to the employee. This is true not only for medical coverage, but also for other benefits that are typically provided on a tax-favored basis (e.g., dental, vision).

Definition of Tax Dependent

To be a federal tax dependent under Code §105(b), the individual must be a "qualifying relative" or a "qualifying child" of the employee as defined by §152 of the Code with certain modifications. To be a qualifying relative, a domestic partner must meet all of the following requirements:

- Reside at the same address as the employee and be a member of the employee's household;
- Receive over half of his or her support from the employee;
- Not be anyone's qualifying child; and
- Be a citizen or national of the U.S., or a resident of the U.S. or a country contiguous to the U.S.

Some employers also offer coverage to the children of a domestic partner who are not dependent children of the employee. To be the employee's Code §105(b) dependent, the domestic partner's child would have to be a qualifying relative of the employee. However, one of the requirements for being a qualifying relative is that an individual must not be a qualifying child of any other taxpayer. A domestic partner's child will often be a qualifying child of the domestic partner and therefore cannot be the employee's qualifying relative.

Employers will typically not know whether a domestic partner or child qualifies as a tax dependent of the employee. The employer may want to adopt a default rule that assumes the domestic partner or child is not a tax dependent unless the employee notifies the employer otherwise. Plan sponsors should communicate this assumption in benefit communications and then provide an opportunity for employees to submit an affidavit that a domestic partner or their children qualify as a Code §105(b) tax dependent when applicable. The IRS has approved the use of employee certifications for verifying tax dependent status.

How to Tax Domestic Partner Benefits

When coverage is provided to a domestic partner (or their child) who is not the employee's tax dependent, the employer must impute the FMV of the coverage as taxable income to the employee. The employee will have imputed income reported on Form W-2 equal to the FMV of the domestic partner's and/or child's coverage, and this amount will be subject to payroll taxes (income and FICA taxes).

The IRS has not provided any official guidance about how to calculate the value of a domestic partner's (or their child's) health coverage, so there is some flexibility in how the employer determines FMV.

- One common approach is to use the plan's COBRA premium for self-only (individual) coverage, not including the 2% COBRA administration fee. If coverage is added for more than one individual (e.g., a domestic partner and his or her child), the COBRA premium for that number of individuals could be used.
- Another possible method is to determine the value based on the incremental cost of adding coverage for the individual. For example, if the monthly plan cost for single coverage is $450 and the cost for Employee+1 is $700, the FMV of the domestic partner's coverage would be $250 ($700 − $450).

In some cases, such as when the employee already carries family coverage, the cost of adding coverage for an individual may be $0.00. But the IRS has made it clear that the coverage still has value and that an appropriate FMV must be included in the employee's income, even if there is no additional premium due.

The mechanics of imputing taxable income will depend on how the coverage is paid for by the employer and the employee.

- If the employer covers the full premium for the domestic partner's coverage (or for his or her child), then the full FMV of the domestic partner's health coverage must be included in the employee's income.
- If the employer and employee share the cost of the monthly premium, it can be handled one of two ways:
    - The employee contributions for the domestic partner's coverage can be paid on an after-tax basis and income imputed equal to the FMV of the domestic partner's coverage minus the employee's after-tax contributions; or
    - The employee contributions for the domestic partner coverage can be paid on a pre-tax basis and then the full FMV of the domestic partner's coverage must be imputed as taxable income.

Some employers impute income only once a year, adding all the imputed income for the domestic partner coverage to the taxable income reported on the employee's W-2 at year's end. Others report the imputed income incrementally throughout the year as the domestic partner coverage is provided. The latter approach allows the employer to calculate and withhold taxes on the imputed income throughout the year and avoid a potential tax surprise for employees when they file their taxes.

Other Compliance Considerations

Health FSA, HRA and HSA Reimbursement

Health FSAs and HRAs are generally only available to reimburse qualifying medical expenses of the employee, the employee's spouse, the employee's child who has not yet reached age 27, and the employee's tax dependents. Therefore, expenses incurred by a domestic partner or the domestic partner's child who are not tax dependents of the employee cannot be reimbursed from a health FSA or HRA.

There is informal guidance from the IRS in Private Letter Ruling 201415011 indicating that an HRA may reimburse qualifying medical expenses for domestic partners, but only if the value of the HRA is imputed as taxable income to the employee in addition to imputing the value of the domestic partner's coverage on any accompanying major medical plan (and assuming the domestic partner is NOT the employee's tax dependent).

Similarly, HSA funds may only reimburse qualifying medical expenses of the HSA account holder and the account holder's spouse and tax dependents on a tax-favored basis. Therefore, the expenses of domestic partners or their children are generally not reimbursable by the employee's HSA, unless the employee is willing to pay the taxes and penalties applicable to ineligible withdrawals. But if the domestic partner is enrolled in the employee's HDHP and is otherwise HSA-eligible, the domestic partner could open and contribute to their own HSA. In addition, the special contribution rule that applies to married spouses with family HDHP coverage would not apply, so the domestic partner and the employee could each contribute up to the family HDHP maximum for the year.

Cafeteria Plan Election Change Rules

Domestic partner premiums paid on after-tax basis are not subject to §125 election change rules, so the employee can therefore drop the domestic partner's coverage at any time unless the employer or carrier implements rules restricting mid-year changes.

HIPAA Special Enrollment Rights

If a domestic partner or their child loses other coverage, the loss of coverage triggers a HIPAA special enrollment event for the employee and the domestic partner or child losing coverage to enroll on the plan mid-year. Only the dependent losing coverage has a special enrollment right though – if the domestic partner's child loses coverage, for example, the employee can enroll the child on the plan via special enrollment but the plan is not required to allow mid-year enrollment for the domestic partner who didn't lose coverage.

Entering into a new domestic partnership is not a HIPAA special enrollment event that would require the plan to allow the employee to add the new domestic partner or their children to the plan outside of open enrollment. If the employee or domestic partner gives birth to or adopts a child, that would be a special enrollment event for the employee and the newly acquired child to enroll on the plan, but not the domestic partner or any other children. That being said, plans that extend coverage to domestic partners could choose to allow mid-year enrollment upon a newly formed domestic partnership or the birth or adoption of a child so long as it is written into the plan documents and agreed upon by the carrier (or stop-loss vendor).

COBRA and State Continuation

Under federal COBRA, only covered employees, spouses, and dependent children may be qualified beneficiaries, so a domestic partner will not be a qualified beneficiary with their own independent COBRA rights. However, if the employee elects COBRA, they will have the same right as an active employee to cover the domestic partner as a dependent on the plan. If the domestic partner was covered when the qualifying event occurred, or is added during open enrollment, the domestic partner may continue coverage as a dependent so long as the employee remains enrolled in COBRA but cannot continue the coverage on their own if the employee drops the COBRA coverage.

For fully-insured plans subject to state continuation requirements, in states which recognize domestic partnerships, the plan may be required to offer state continuation coverage to domestic partners in some cases (e.g., under CalCOBRA).

Medicare Secondary Payer

Normally, for an employer with 20+ employees (100+ in the case of disability-based Medicare), a group health plan would be the primary payer to Medicare for an active employee and their spouse enrolled on the group health plan. But because a domestic partner is not the employee's spouse, Medicare would be the primary payer for the domestic partner, even if the employee is still actively working. That means Medicare will pay first if the domestic partner is enrolled in both Medicare and the group health plan. If the group health plan has a Medicare Estimation clause (i.e., group health plan pays secondary to Medicare whenever Medicare is primary, even if the participant does not actually enroll in Medicare), it would leave the domestic partner with very limited coverage if the domestic partner does not enroll in Medicare upon becoming eligible. In addition, because Medicare is primary over the group health plan for the domestic partner, group health plan coverage will not hold off the Medicare Part B late enrollment penalty the way it would for a spouse. If the domestic partner does not sign up for Medicare when first eligible, they may find themselves having to pay a permanent late enrollment penalty when they finally do enroll in Medicare Part B down the road.